MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

SCHOOL VISION SCREENING FORM

IDENTIFYING INFORMATION	REASON FOR SCREENING
STUDENT NAME	☐ TEACHER REFERRAL ☐ ROUTINE SCREENING
GRADE	TODAYS DATE
SCHOOL YEAR	

OBSERVATIONS

APPEARANCE	BEHAVIOR	COMPLAINTS
☐ RED EYES	☐ BLINKING	☐ CAN'T SEE BLACKBOARD
☐ GRANULATED LIDS	☐ WATERING EYES	☐ PRINT BLURS
☐ STYES	☐ SENSITIVE TO LIGHT	☐ DOUBLE VISION
☐ DISCHARGE	☐ RUB EYES	☐ HEADACHE
☐ SWELLING ABOUT EYES	☐ EXCESSIVE FROWNING	☐ NAUSEA
☐ HEAD TILT	☐ IRRITABILITY WHEN USING EYES	☐ DIZZINESS
☐ DROOPY LIDS	☐ SQUINTS OR SQUEEZES LIDS	☐ OTHER
☐ EYES OUT OF LINE	☐ HOLDS BOOK VERY CLOSE	
☐ STUMBLES/TRIPS OVER SMALL OBJECTS	☐ OTHER	

SCREENING DATE _____

☐ WEARING GLASSES ☐ GLASSES BROKEN/LOST ☐ GLASSES AT HOME ☐ DOES NOT WEAR GLASSES

DISTANCE ACUITY	RIGHT 20 / LEFT 20 /	CHART USED
NEAR ACUITY	RIGHT 20 / LEFT 20 /	CHART USED
BINOCULARITY	TYPE OF TEST	☐ PASS ☐ FAIL

RE-SCREENING DATE _____

☐ WEARING GLASSES ☐ GLASSES BROKEN/LOST ☐ GLASSES AT HOME ☐ DOES NOT WEAR GLASSES

DISTANCE ACUITY	RIGHT 20 / LEFT 20 /	CHART USED
NEAR ACUITY	RIGHT 20 / LEFT 20 /	CHART USED
BINOCULARITY	TYPE OF TEST	☐ PASS ☐ FAIL

PASS ☐ **REFER** ☐ **DATE OF REFERRAL** **DATE EYE EXAM REPORT RECEIVED**

If unable to complete vision screening, please conduct a functional vision assessment.